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# THESIS

**CHANGING ROLES AND MISSIONS OF THE MEDICAL BRANCH OF THE NAVAL RESERVE DURING THE PERIOD 1987-1995**

by

Herbert L. Zick

December, 1996

Thesis Advisor: Richard B. Doyle

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This thesis examines the changing roles and missions of the medical branch of the Naval Reserve in the post-Cold War period. These changes were brought about by the end of the Cold War, the subsequent drawdown, and the need to make better use of the resources of the United States Navy. It draws primarily on Navy and Department of Defense Instructions, General Accounting Office and Department of Defense Inspector General reports and Congressional hearings. Personal interviews with CNRF, CNSRF, and BuMed were also utilized. Four areas of change were identified. These areas are use of the Reserves to provide (1) a reduction in Active Component OPTEMPO /PERSTEMPO, (2) contributory support at CONUS MTF's, (3) humanitarian and peacekeeping assistance, and (4) single-sourcing of Fleet Hospitals. Two changes, reduction in Active Component OPTEMPO /PERSTEMPO and contributory support at CONUS MTF's have been fully implemented. Humanitarian and peacekeeping assistance is an area in which the medical branch of the Naval Reserve expects (but has yet to) be employed. Single-sourcing of Fleet Hospitals is a new initiative that has additional requirements for the medical branch of the Naval Reserve. Finally, the relationship between training policies and programs and these changed roles and missions is discussed.

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# CHANGING ROLES AND MISSIONS OF THE MEDICAL BRANCH OF THE NAVAL RESERVE DURING THE PERIOD 1987-1995

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## ABSTRACT

This thesis examines the changing roles and missions of the medical branch of the Naval Reserve in the post-Cold War period. These changes were brought about by the end of the Cold War, the subsequent drawdown, and the need to make better use of the resources of the United States Navy. It draws primarily on Navy and Department of Defense Instructions, General Accounting Office and Department of Defense Inspector General reports and Congressional hearings. Personal interviews with CNRF, CNSRF, and BuMed were also utilized. Four areas of change were identified. These areas are use of the Reserves to provide (1) a reduction in Active Component OPTEMPO /PERSTEMPO, (2) contributory support at CONUS MTF's, (3) humanitarian and peacekeeping assistance, and (4) single-sourcing of Fleet Hospitals. Two changes, reduction in Active Component OPTEMPO /PERSTEMPO and contributory support at CONUS MTF's have been fully implemented. Humanitarian and peacekeeping assistance is an area in which the medical branch of the Naval Reserve expects (but has yet to) be employed. Single-sourcing of Fleet Hospitals is a new initiative that has additional requirements for the medical branch of the Naval Reserve. Finally, the relationship between training policies and programs and these changed roles and missions is discussed.

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# I. INTRODUCTION

## A. BACKGROUND

The Department of the Navy (DoN) maintains a sizeable number of medical professionals in the Selected Reserves. The purpose of medical professionals in the Selected Reserves is to provide a reliable source of trained medical personnel who can be mobilized quickly in the event of armed conflict. Upon mobilization, the vast majority of SelRes doctors and nurses would be mobilized in one of three methods. The first role is to take the place of their deployed Active Component counterparts at CONUS Medical Treatment Facilities (MTFs). Other SelRes would themselves deploy, either aboard a hospital ship or to a Fleet Hospital. Their importance, value and utility was validated during the Persian Gulf war. Reserve Component personnel augmented the staffs of CONUS hospitals, and deployed both to hospital ships and Fleet Hospitals.

The Persian Gulf war was fought at the end of the largest peacetime defense buildup in history. Since the end of the Cold War, the size and structure of the United States military in general, and specifically the Navy, has changed substantially. This thesis will examine what these size and structure changes are and how they have affected the medical branch of the Naval Reserve as compared to the rest of the Navy. Also, the forces, both internal and external, that have caused these changes will be reviewed.

The period following the Cold War was one of unprecedented upheaval,

both within the confines of the United States Navy and world wide. The Soviet Union and Eastern Bloc nations disintegrated into several smaller countries with borders based on geography, history and culture. Peacekeeping, humanitarian relief (both domestic and abroad) and similar "Operations other than War" became important new missions for the United States Navy, including Navy Medical.

But while the Navy was taking on these additional duties in places like Bosnia, Somalia, and Rwanda, the movement at home was one of force reductions and downsizing in an attempt to reap the so-called Cold War "Peace Dividend". During this period, September 1987 to September 1995, the U.S. Navy total end strength declined 25 per cent and the per cent of personnel eligible for health care declined 14 per cent. However, during this same period the medical branch of the Naval Reserve increased in size 5 per cent and the officer ranks (Doctors and Nurses) increased 89 per cent.[1]

Within the framework of force reduction and cost-cutting this growth has several implications. The first implication is an increased reliance on the medical branch of the Naval Reserve by the Active Component to accomplish tasks previously completed by the Active Component. Second, this growth implies new roles and missions (most of which are a product of the end of the Cold War)

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[1] Defense Manpower Data Center, Navy Health Care Right-Sizing: A Comparative Demographic Profile of the Department of Defense Workforce September 1987 versus September 1995, April 1996, p.16.

for the medical branch of the Naval Reserve. Third, this growth could simply be the result of tremendous success in recruiting and retention efforts by the Naval Reserve. Fourth, the growth could be a combination of all three.

Finally, this thesis will examine the scope of training required to maintain the readiness of Selected Reserve medical professionals within the constraints of the reserve program. Current military and medical training policies and programs will be discussed in order to estimate the level of training required to mobilize a Selected Reserve medical professional.

## B. OBJECTIVES

The primary purpose of this thesis is to identify and examine changing roles and missions of the Navy's Reserve Medical Corps during the period of the ending of the Cold War and the consequent drawdown, from September 1987 to September 1995. Secondary purposes include reviewing demographic changes in the medical branch of the Naval Reserve to illuminate the magnitude of the change in roles and missions, and reviewing training policies and programs to how they reflect changes in the medical branch of the Naval Reserve.

## C. RESEARCH QUESTIONS

This thesis will attempt to answer the following questions:

- What are the historic roles and missions of the medical branch of the Naval Reserve?
- What are the changing roles and missions of the medical branch of the Naval Reserve as a result of the end of the Cold War and the

subsequent downsizing reflected in the substantial increase in SelRes medical professionals?

- How does the Reserve (Selected Reserve, Individual Ready Reserve, etc.) program work in peacetime? What is the Reserve force structure, and how does it factor into the 89 percent increase in SelRes medical professionals.
- How are SelRes medical professionals being employed in view of their increased numbers, i.e., 89 percent since 1987.
- What is the relationship of the training and readiness of SelRes medical professionals to the new roles and missions of the medical branch of the Naval Reserve.

## D. SCOPE OF THESIS

The scope of this thesis is limited to examining the changing roles and missions of the medical branch of the Naval Reserve and how those are reflected in changing demographic data. This thesis also investigates the relationship between training policies and programs and the new roles and missions. In order to keep this thesis at the unclassified level, classified portions of Reserve mobilization plans and instructions will not be discussed.

## E. METHODOLOGY

This thesis relied primarily on a deductive approach to the question of identifying and analyzing the changing roles and missions of the medical branch of the Selected Reserves. Preliminary data was gathered primarily through

telephone conversations and by reviewing available literature, General Accounting Office reports, DoD Inspector General Audit Reports, Masters Theses and government contracted studies. I conducted telephone interviews with key individuals, including Commander, Naval Reserve Force; BUMED (MED-07, Reserve Integration), and the Office of the Director, Medical Resources, Plans, and Policies (N931).

## F. ORGANIZATION OF STUDY

Chapter I provides a brief introduction and background regarding the growth and employment of medical professionals in the Selected Reserves. Chapter I will provides an overview of this thesis' organization, methodology, objectives, and scope.

Chapter II gives an overview of the historical roles and missions of the medical branch of the Naval Reserve. It summarizes the status of the medical branch of the Naval Reserve as of 1987. This chapter draws extensively on a study entitled "Navy Health Care Right-Sizing, a Comparative Demographic Profile of the Department of Defense Workforce, September 1987 versus September 1995." Organization and operation of the Naval Reserve are also discussed.

Chapter III discusses the changing roles and missions of the medical branch of the Naval Reserve. The impact of the end of the Cold War on the Navy in general, and the medical branch of the Naval Reserve specifically, is examined.

Chapter IV discusses of differences between the practice of medicine in the military and that of the civilian environment. Training policies are reviewed, with particular attention to DoD Directive 1215.4, "Medical Training in the Reserve Components." The various training programs and how they support the training policies, are reviewed. Finally, these are related to the original question of how the roles and missions of the medical branch of the Naval Reserve have changed during the period from 1987 to 1995. This is done by showing that the training programs and policies support the expanded roles and missions discussed in chapter III, namely reduction of the Active Component OPTEMPO/PERSTEMPO through increased use of SelRes medical professionals, humanitarian and peacekeeping missions, and contributory support.

Chapter V summarizes the information in the preceding chapters and provides conclusions and recommendations for further study.

## II. OVERVIEW OF THE MEDICAL BRANCH OF THE NAVAL RESERVE

### A. NAVAL RESERVE PERSONNEL CATEGORIES

Established in 1915, the Naval Reserve has played a significant role in time of peace and conflict. From World War I to the Persian Gulf war, Reservists have provided an economical method of providing trained personnel on short notice. In World War II, approximately seventy-five percent of the officers and enlisted men who served on active duty with the Navy were Reservists.[2] With the end of the draft in July 1973, Reserves "have replaced the draft as the principal means for expanding military forces in a national emergency."[3] During the Persian Gulf War, over half of the Reservists who deployed to the Persian Gulf were Medical specialists.[4]

However, the term "Reserves" does not refer to a single, amorphous body of military force. Rather it refers to groups of personnel that can be rank ordered in terms of their readiness to mobilize. Table 1 graphically demonstrates the breakdown of the Reserve Force structure. The two primary subsets of this group are the Ready Reserves and the Standby Reserves. The Ready Reserves can be further subdivided into two groups: Active duty reservists and

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[2] Secretary of the Navy, A Report to the Congress on the Navy's Total Force, Department of the Navy, February 1985.

[3]Martin Binkin, U.S. Reserve Forces: The Problem of the Weekend Warrior, (Washington D.C.: The Brookings Institute, 1976), pg. 22.

[4]Charles E. Heller, Total Force: Federal Reserves and State National Guards, Army War College, 1994, pg. 32.

Inactive duty reservists.

**Reserve Categories**

| Ready Reserves | | Standby Reserves |
|---|---|---|
| Active | Inactive | Retired |
| Active Duty Training and Administration of Reserves | Selected Reserves<br>Individual Ready Reserves<br>Naval Reserve Officer Training Corps | |

**Table 1**

Active duty reservists fall into two categories. The first are those reserve personnel serving full-time on active duty. Newly commissioned officers and first term enlistees typically make up a large portion of this group. They may be in virtually any community, and may become part of the regular navy at a later date. The second group is comprised of full time active duty careerists who administer the Reserve program on a daily basis. They are referred to as TARs (Training and Administration of Reserves). They differ from the above group because they only serve in TAR billets, whereas the first group may serve in any billet for which they qualify.

Inactive duty reservists fall into one of three categories; Reserve Officer Training Corps (ROTC) students, Individual Ready Reservists (non-drilling), and Selected Reservists (drilling). The Selected Reserves, or "SelRes" personnel, comprise the military force most people think of when discussing "the Reserves".

Regarding medical personnel, "The Selected Reserve Component is the difference between the trained manpower needed at the start of a protracted conventional war and the limited Active Navy we can afford and attain in peacetime."[5] They are the personnel who perform drill weekends once a month (hence the term "Weekend Warrior"), and at least two weeks per year of active duty for training (ACDUTRA).

SelRes medical professionals are at the center of this study. They are the first group of Reserves that would be called up in the event of mobilization. They would also be employed to support whatever new missions may be undertaken by the medical branch of the Naval Reserve. They represent the primary cost factor in maintaining the medical branch of the Naval Reserve in that they receive regular pay for drill weekends and retention and incentive bonuses to stay in the Naval Reserve. Other groups (i.e., IRR, Standby) receive no regular pay or compensation.

The Individual Ready Reserve are personnel recently released from active duty with the regular Navy. They do not perform any drill periods and are completely disassociated from the Navy except that they are subject to recall in the event of mobilization. This is because of their currency in their particular military skill.

Standby Reservists and Retired Reservists are the largest subset in the

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[5]Secretary of the Navy, A Report to the Congress on the Navy's Total Force, Department of the Navy, February 1988.

Naval Reserve. This group is mostly comprised of retirees who have completed a full twenty year career. Like Individual Ready Reserve personnel, they are maintained in the roles with no expectation of performance of duty. Being an older group of people, they are the furthest down the mobilization ladder. As with the IRR, there is no pay, compensation, or benefit cost associated with maintaining them in the Naval Reserve.

In 1988, the Standby and Retired Reserves comprised 44.3 percent of all inactive Navy Reserve forces, Selected Reserves 33.7 percent and Individual Ready Reserves 22 percent. Admittedly, these numbers have probably changed since 1988.

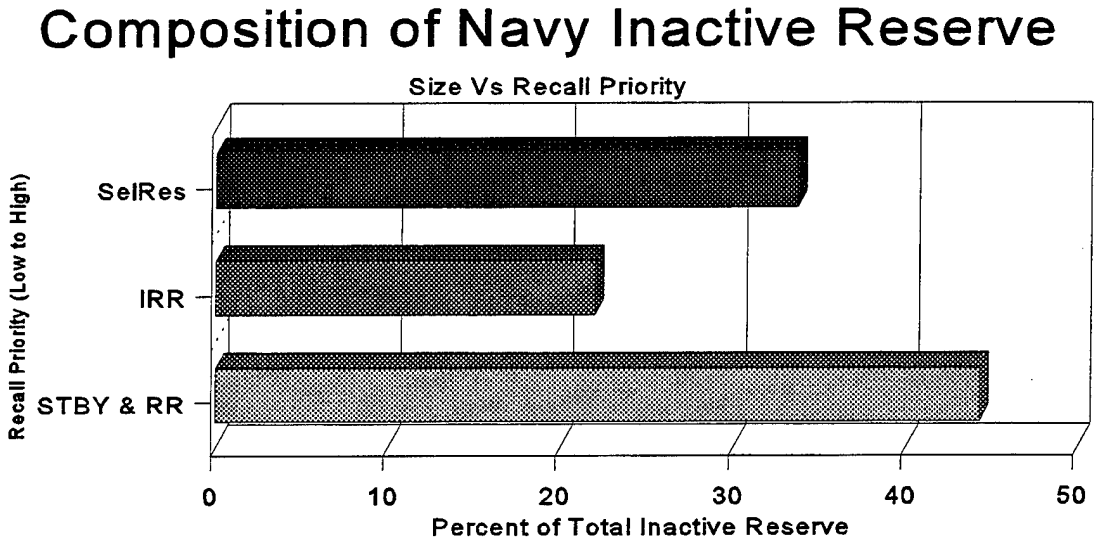


**Figure 1**

Source: Secretary of the Navy, A Report to the Congress on the Navy's Total Force, Department of the Navy, February 1988, pp. 1-2.

Figure 1 provides a graphical presentation of the relative size of the Inactive Reserve. The "Y" axis shows the various groups in increasing order of preparedness to mobilize.

**1. Naval Reserve Medical Programs**

Today within the Naval Reserve, five separate medical programs, numbered 5, 7, 9, 32, and 46 exist. Program number 5 is medical support of Naval Aviation. Program number 7 is medical support of the Seabees. Program 9 is medical support of the Marine Corps. Program 32 is CONUS backfill of Fleet Hospitals. Under this program, Reserve medical professionals would, in times of conflict or crisis, be ordered to a U.S. Navy hospital located in the continental United States. Their purpose would be to assume the jobs of Active Component Medical professionals who have deployed, or soon will deploy, to a Fleet Hospital because of a crisis. Program 32 is usually referred to as the "CONUS Backfill" mission. Backfill of the hospital ships *USS Mercy* and *USS Comfort* also comes under program 32. Finally, program 46 is the Reserve Fleet Hospital program, in which Reservists deploy directly to the region of conflict and operate a temporary, mobile fleet hospital. It is different from program 32 in which Reservists backfill CONUS Hospitals vice manning one of four deployed Reserve Fleet Hospitals.

Of these programs, numbers 5 and 7 account for less than 2 per cent of

all Reserve medical professionals.[6] Programs 32 and 46 account for almost all the remainder of the Selected Reserve medical professionals. Table 2 indicates the allocation of Selected Reserve medical professionals to these programs.

| Navy Selected Reserve Medical Programs | | |
|---|---|---|
| Program Number | Program Title | Percent of Total SelRes Medical Force |
| 5 | Naval Aviation | 0.63% |
| 7 | Construction Battalions | 0.51% |
| 9 | Marine Corps | 6.30% |
| 32 | CONUS Backfill of Naval Hospitals and Hospital Ships | 65.00% |
| 46 | Reserve Fleet Hospitals | 27.40% |

**Table 2**

Source: Naval Reserve Personnel Center Report 40-80-120-7A, 31 August 1996.

## B. RESERVE FORCE STRUCTURE

This discussion draws extensively upon a study, entitled "Navy Health Care Right-Sizing, A Comparative Demographic Profile of the Department of Defense Workforce, September 1987 versus September 1995," completed in April 1996 by the Defense Manpower Data Center (DMDC)[7]. The data base used

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[6]Interview with LCDR Rick Maiello, BuMed 07, Washington D.C., 23 July 1996.

[7] DMDC is a subsidiary of the Office of the Secretary of Defense and provides statistical data and analysis to all branches of the armed forces. DMDC serves as a central repository of manpower statistics and as such maintains an extremely large number of statistical data bases for the DoD.

by DMDC to produce this study is called the "Reserve Components Common Personnel Data System" (RCCPDS). DMDC receives monthly reports from various reserve field activities to maintain the RCCPDS data base. This reporting is completed as required by Department of Defense Instruction 7730.54.

The DMDC study cited above attempted to answer the question "What were the demographic changes in the Navy health care provider population, in end strength numbers, from 1987 to 1995." In completing the study, DMDC consolidated various DoD occupations into one group called "DOD Health Care Professionals." Navy officer health care professionals are comprised of four groups: Doctors, Nurses, Dentists, and Medical Service Corps (MSC). (Other services have veterinarians which are included in the group, but there are none in the Navy.) This grouping is codified in DoD Publication 1312.1-I, Occupational Conversion Index, and is designed specifically for analytical purposes.

DMDC found that total Navy end strength declined 28 percent overall from 1987 to 1995, and the number of personnel eligible for health care under the Defense Health Program (DHP) decreased 14 percent. This latter number represents a "best guess" of workload for Navy health care professionals. It only accounts for those who were eligible to receive military medical treatment; it says nothing about those who actually sought care or received treatment.

Between September 1987 and September 1995, the Navy health care force, officer and enlisted, increased 3 percent for the Active forces and 5

percent for the Reserve forces. Table 3 presents the growth of Navy medical professionals during this time period. The number of Reserve health care officers increased from 2,188 to 4,130, an increase of 1,942 or 89 percent. During the same period, active duty health care officers increased from 8,407 in September 1987 to 9,578 in 1995, an increase of 14 percent. Further, in 1987 the number of Reserve health care officers as a percent of all (Active and Reserve) Navy medical professionals (2,188 divided by 10595) was 21 percent. By 1995 that number (4,130 divided by 13708) had increased to 30 percent. Another way to view this increase is to look at what percent of all Navy officers were Reserve Health Care professionals. In 1987, Reserve Health Care professionals constituted 8 percent of all officers in the Navy. By 1995 that percentage had more than doubled to 17 percent. Table 3 summarizes these numbers.

**Growth of Navy Medical Professionals from 1987 to 1995**
Reserve Vs. Active

| | 1987 | 1995 | Delta | Increase |
|---|---|---|---|---|
| **Active Officer** | 8407 | 9578 | +1171 | +14% |
| **Reserve Officer** | 2188 | 4130 | +1942 | +89% |
| **Reserves as % of All Medical Professionals** | 21% | 30% | +9% | |

**Table 3**

Source: Defense Manpower Data Center, Navy Health Care Right Sizing, A Comparative Demographic Profile of the Department of Defense Workforce, September 1987 versus September 1995.

## C. CHAPTER SUMMARY

This chapter briefly reviewed the history and background of the Naval Reserve within the context of the United States military. It also described the organization and subdivisions of the Naval Reserves. Selected Reservists are part of the Inactive Reserves and are the top priority during mobilization. Individual numbered programs of the Naval Reserve (Aviation, Seabees, Marine Corps, CONUS Backfill, and Fleet Hospital) were identified and described.

The chapter then reviewed the findings of a study completed in April 1996 by the Defense Manpower Data Center (DMDC). This study examines the demographic changes within Navy medicine, and particularly the medical branch of the Naval Reserve. The study indicated that during the period of the post-

Cold War drawdown (1987-1995), the number of Medical professionals (Doctors, Nurses, Dentists, and Medical Service Corps) in the Selected Reserves increased 89 percent.

## III. CHANGES IN ROLES AND MISSIONS

### A. BACKGROUND

This chapter examines the changing roles and missions of the Navy, its Medical Corps, and the methods by which Selected Reserve Medical professionals are employed to help the Navy meet these roles and missions. Any discussion of changing roles and missions within the United States Armed Forces during the period from 1987 to 1995 is incomplete without a brief discussion of what the roles and missions were before 1987 to provide a historical context.

Almost from the end of the Second World War to the end of the Cold War and the advent of what President George Bush called "a new World Order," the primary focus of United States Armed Forces was to contain the spread of Communism, provide a credible nuclear deterrent to the Soviet Union, and be prepared to fight a major land war on the European continent to defeat the Red Army. The forces required to do this, in terms of both personnel and material, were substantial. The medical force necessary to support the war fighter in the event of a major war was similarly significant. This support is usually referred to as the Medical Department's "wartime mission".

Further, since conflict with the USSR was assumed to be both inevitable and to occur with minimal warning, the wartime mission could only be filled by medical professionals serving on active duty. The time required to recall and mobilize reserve Doctors and Nurses would result in too great a delay. To be of

any service, they had to be serving on active duty "when the balloon went up". The obvious result of this was that a surplus of Doctors and Nurses existed to care for the Active duty war fighters during peacetime. The existence of this surplus contributed to the Medical Department's second mission, also known as the "peacetime benefit."

The peacetime benefit mission entails providing health care to dependents of active duty personnel, retirees and their dependents, and survivors of retirees. Thus the wartime mission mandated a large number of medical professionals on active duty status and the peacetime benefit provided services to a population of beneficiaries while the professionals kept their medical skills current. It was a system which benefitted all concerned.[8]

With the demise of the Soviet Union in 1990, a major land war with a high casualty rate on the European continent no longer seemed likely. Smaller regional conflicts appeared the more likely scenario. Because a large standing force is no longer required, lower casualty rates are expected, and the onset of hostilities is expected to take longer. Thus, a large active duty medical force becomes unnecessary.

Operation Desert Shield, which followed the Iraqi invasion of Kuwait, serves as an example of future regional conflicts in which the United States may find itself involved. The slow build-up of forces in the Theater of Operations

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[8]Copenhaver, Kimberly A., Navy Health Care Readiness Requirement Model and Programming Costs, Naval Postgraduate School Thesis, December 1994, pg.1.

allows sufficient time to recall and mobilize reserve forces, including health care providers. Dr. Stephen Joseph, Assistant Secretary for Health Affairs, summarized these changes in an address at a Department of Defense Tricare conference. Dr. Joseph noted:

> Our military missions range from disaster assistance to peacekeeping to peacemaking to conflict and war. The way we carry out those missions is to rapidly project the appropriate force to the area of need. In most instances, the size force required is small compared to the force mobilized for Operation Desert Storm or to that planned for the defense of Western Europe. The thrust of the department today is to assemble and train the U.S. armed forces as flexible, highly mobile, technologically expert units prepared to deploy anywhere in the world. This involves creating a smaller forward footprint.[9]

In 1991, Congress mandated a systematic review of the military medical care system required to support the Armed Forces in time of conflict. This review became known as the "733 Study". A Department of Defense Inspector General report summarized the 733 study as follows:

> The 733 study reported that only 6,300 active physicians are required to meet the requirements of two simultaneous conflicts. The projected number of active duty DoD physicians for FY 1999 totals 12,600 or twice the number needed for readiness according to the 733 study. The Military Department surgeons general disagreed with the conclusions of the 733 study and a follow-on study was ongoing at the time of the audit. [10]

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[9]Dr. Stephen Joseph, "Military Medicine: In Step, Adept, Flexible", Prepared remarks to the DoD TRICARE Convention, Washington D.C., January 22, 1996.

[10]U.S., Department of Defense, Office of the Inspector General, DoD Graduate Medical Education Programs and Medical Readiness Training, Report Number 96-168, June 18, 1996.

## B. CHANGES IN ROLES AND MISSIONS

There are four distinct changes to the roles and missions of the medical branch of the Naval Reserve. The first is an attempt to reduce the OPTEMPO/ PERSTEMPO of the Active Component through increased use of the Reserves. The second is the contributory support mission. Third is the use of Reserve Medical personnel in support of humanitarian and disaster relief missions, both domestically and abroad. This mission has frequently been tied to United Nations' peacekeeping efforts in the recent past. The fourth change is referred to as "Single-Sourcing" of Fleet Hospitals.

The first change cited above, we will see, is a direct result of downsizing. The second is an attempt to fully and seamlessly integrate reserve forces into the Total Force of the United States Navy. The third is, partially, a result of world instability caused by the end of the Cold War. The fourth is the result of a lesson learned from the Persian Gulf War.

The first two changes, use of Reservists to reduce Active Component OPTEMPO/PERSTEMPO and the contributory support mission, are truly revolutionary, vice evolutionary, in nature. They did not exist before the end of the Cold War. In fact, it was the end of the Cold War that brought these changes about. Reduction of the size of the Active Component without a compensatory reduction in military commitments mandated increased use of Reservists to keep Active Component OPTEMPO/ PERSTEMPO at acceptable levels. Contributory support can also be viewed as a result of the end of the Cold War. Because the

onset of hostilities is now viewed as occurring much more slowly, and Reservists more likely to be employed, full integration of SelRes is essential.

The humanitarian /peacekeeping mission, on the other hand, is more evolutionary than revolutionary because it existed before the end of the Cold War. However, it has received much more interest from both Active and Reserve Components since the end of the Cold War. Single-Sourcing of Fleet Hospitals is also evolutionary. Reservists have always backfilled at CONUS MTF's and manned Reserve Fleet Hospitals. Single-Sourcing simply changes the assignment method. Each of these changes in roles and missions are discussed in further detail below.

### 1. Use of Reservists to Reduce Active Component OPTEMPO/PERSTEMPO

The changing roles and missions of the Naval Reserve Medical Corps are impacted both by the environment in which Navy roles and missions are defined and by the changing force structure necessary to satisfy national security requirements. The first, alluded to above, is the direct descendant of the wartime mission. The capability of the Medical Corps to provide medical services to the war fighter remains paramount. That, obviously, is the "raison d'etre" of the Medical Corps.

Reduction in the size of the Active Forces necessitates the use of SelRes medical professionals to augment the active duty forces. This is because of the concept known as OPTEMPO/PERSTEMPO. OPTEMPO /PERSTEMPO are

statistical measures of activity. OPTEMPO measures the level of activity of a military unit, while PERSTEMPO measures the level of activity of individuals in the military.[11] Maintaining or reducing OPTEMPO /PERSTEMPO is an important factor in quality of life standards, and therefore retention.

With smaller Active forces, but static or increased mission requirements, one method of maintaining Active Component OPTEMPO/PERSTEMPO is to use SelRes doctors and nurses to perform duties previously the exclusive province of the active duty Medical Corps. Assistant Secretary for Reserve Affairs Deborah Lee pointed out that:

> [F]or FY 96 and FY 97, Secretary Perry has provided $25 million additional dollars per year--funds that will be matched by Services and the CinCs--to help cover incremental mandays and transportation costs associated with sending more Reservists where the work needs to be done. The primary focus of these initiatives will be to relieve active PERSTEMPO.[12]

Subsequently the Joint Chiefs of Staff sent a message noting "' the Increased use of Reserves Program' will be extended into FY 97 and institutionalized in

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[11]For example, in the United States Navy surface forces, OPTEMPO is derived by dividing the number of days a ship is underway by the total days in the statistical period. PERSTEMPO, on the other hand, is obtained by dividing the individual's total days out of homeport by the total days in the statistical period. So if a San Diego-based ship was in port in Pearl Harbor, that day would count toward PERSTEMPO, but not OPTEMPO.

[12]Deborah Lee, Prepared remarks to the AMSUS convention, Los Angeles, CA, October 30, 1995.

the Programming and Budget cycle for FY98 and beyond."[13]

**2. Use of Reservists in Contributory Support**

Yet another fundamental change in the roles and missions of reservists is in the area of peacetime contributory support. This support is defined as a "readiness related activity, supporting the mission of the active component."[14] In practice, contributory support means that instead of conducting formal training during drill periods, SelRes Medical personnel work on the staff of various Naval medical treatment facilities. The Integrated Medical Department Support Plan, which is the model for contributory support, was described by the then Surgeon General of the Navy, Vice Admiral Donald F. Hagen, as follows:

> The plan emphasizes full integration of reserve medical personnel into the staffs of our treatment facilities to maximize the amount of contributory support they provide. Reserve weekend programs, including the Same Day Surgery programs... continue to grow and expand the scope of services they provide.[15]

Vice Admiral Hagen also noted that:

> Maintaining readiness in the face of health care reform can only be accomplished by using all of Navy Medicine's valuable assets, including our Navy Medical reservists. The contributory support they provide improves access to care, reduces CHAMPUS

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[13]Joint Chiefs of Staff, Washington, D.C., Radio Message dated 052202Z February 1996.

[14]Bureau of Medicine and Surgery Instruction 1001.3, "Integration, Use, and Training of Reserve Medical Personnel.", 20 April 1993, pg. 2.

[15]U.S., Congress, Senate, Statement of Vice Admiral Donald F. Hagen, MC, Surgeon General United States Navy, April 14, 1994, Before the Subcommittee on Defense, Senate Appropriations Committee.

expenditures, and provides valuable mobilization training.[16]

A subtle but important change in how contributory support is viewed is highlighted by comparing two policy statements, one from 1993 and one from 1996. The first statement, contained in BuMed Instruction 1001.3, states that "units and individuals not having a primary role of crisis response, will be available to provide peacetime (contributory support)."[17] This implies that those SelRes having "crisis response" as a primary mission will not be available to provide contributory support. This suggests that while readiness is the major mission, contributory support was to be offered only by individuals who did not have crisis response as their primary mission responsibility.

In contrast, a more recent comment from the Commander, Naval Surface Reserve Forces, states that:

> [T]he mission of the Naval Surface Reserve Force is to maintain assigned personnel and equipment in a high state of readiness and availability which will permit rapid employment in the event of partial or full mobilization and to provide peacetime contributory support to the active Navy as required. [18]

In other words, the Commander, Naval Surface Reserve Forces (CNSRF) views contributory support as equally important as readiness for full mobilization.

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[16]Ibid.

[17]Bureau of Medicine and Surgery Instruction 1001.3, "Integration, Use, and Training of Reserve Medical Personnel.", 20 April 1993, pg. 2.

[18]Commander, Naval Surface Reserve Force Instruction 5400.1B, pg. I-1, 1 July 1996.

A primary method for effecting contributory support is through solicitation of Active commands in need of augmentation by SelRes. Active commands make their requirements known through their respective CinC's, who refer them to the Commander, Naval Reserve Force (CNRF).

The demand by the Active Component for SelRes medical professionals is high. As an example of the demand, CNRF routinely sends via radio message offers for Additional Training (AT) opportunities to members of the Selected Reserves. On a recently transmitted message, fifty-nine percent of all training listed on the message applied to medical professionals.[19] This AT is conducted at commands both in CONUS and overseas. While it is called "training," it is, in fact, contributory support. The volunteer SelRes reports to the command which requested augmentation by a SelRes medical professional and works in his area of expertise.

The extent to which the Navy has come to rely on contributory support was noted by VADM James A. Zimble, then Surgeon General of the Navy. In his remarks before Congress, he pointed out:

> The Selected Reserves are an integral part of the Navy's Healthcare delivery team. They provided over 600 man-years of support to the Active Medical and Dental Treatment Facilities around the world this past fiscal year. Much of this support was

[19]Commander, Naval Reserve Forces, Radio Message dated 112000Z July 1996.

provided in critical specialties during times of acute need.[20]

### 3. Use of Reservists to Conduct Humanitarian and Peacekeeping Missions

The third change in roles and missions of the medical branch of the Naval Reserves is the area of humanitarian and peacekeeping operations, both internationally and domestically. This is a mission that the United States military as a whole has already undertaken, but one for which the reserves have just started preparing. The 1990's have already provided several textbook cases of United States military medicine supporting United Nations sanctioned peacekeeping operations. These, of course, are in Bosnia, Somalia, Rwanda, and Northern Iraq. These efforts have become missions of the United States military partly because only the United States military has the necessary organization, technology and capability to complete these tasks. Captain Paula Ryals, Commanding Officer, Naval Reserve Combat Zone 500 Fleet Hospital 21 noted:

> The military is the best organization for the rapid mobilization and deployment of assistance to complex humanitarian emergencies. The military can provide rapid and sustained relief using trained and disciplined personnel, and can provide its own transportation, supplies, communications, shelter, food, water, sanitation, and security.[21]

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[20]U.S., Congress, Senate, Statement of Vice Admiral James A. Zimble, MC, Surgeon General United States Navy, March 20, 1990, Before the Subcommittee on Defense, Senate Appropriations Committee.

[21]Captain Paula A. Ryals, MC, USNR, "Military Medicine in Operations Other Than War Part II: Humanitarian Relief Missions for Naval Reserve Fleet Hospitals",

This change, like the others, was also made possible by the end of the Cold War. The end of the Cold War allows freedom of movement for United States military forces. No longer required to stay in Western Europe as a deterrent to Soviet aggression, military forces can be moved as necessary to meet the humanitarian or peacekeeping need. Chairman of the Joint Chiefs of Staff, General Shalikashvili summed up this point when he said:

> After the Cold War, both Presidents Bush and Clinton could more easily and with less risk use American forces to secure not just vital interests, but also less important interests. They also more readily used military forces to achieve humanitarian interests in places like Northern Iraq or in Rwanda, where the humanitarian crises were so enormous that they overwhelmed regular humanitarian organizations.[22]

The Naval Reserves, in general, have taken on this role throughout the world. In the recent past:

> The Naval Reserve mobilized in support of Operation Uphold Democracy in Haiti. Numerous volunteers participated in Operations Able Vigil in the Florida Straits off Cuba, Provide Hope in Rwanda, and Provide Promise in Croatia.[23]

As the then Surgeon General of the Navy VADM Hagen noted in 1994, "Our reserve medical personnel are also poised for immediate crisis response.

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Military Medicine, vol. 161: September 1996, pg. 502.

[22]General John M. Shalikashvili, "The DoD-CARE Humanitarian Connection." Prepared remarks to the CARE 50th Anniversary Symposium, Washington, D.C., May 10, 1996.

[23]Office of the Assistant Secretary of Defense for Reserve Affairs, "An Introduction to the Reserve Components of the United States", 21 February 1995, pgs. 5-6.

Two Reserve Fleet Hospitals are fully manned and trained to respond to any contingency upon mobilization."[24]

Because of their varied background and experience, SelRes medical professionals often have skills and knowledge different from their Active Component counterpart. These differences can be of significant utility.

> As active duty assets draw down, reservists provide a unique pool of personnel who can respond to unexpected requirements without degrading active duty missions. Reserve medical personnel often have substantial training and experience, many have academic appointments, and as a rule many have a great deal more exposure to trauma and other aspects of specialized medical care.[25]

Regarding the use of reserves in humanitarian missions domestically, Congress mandated a study to ascertain how reserve forces could be employed to respond to domestic emergencies and national contingencies. In the FY97 Defense Authorization Conference report, Congress directed the Secretary of Defense to:

> Submit to Congress a report regarding reserve component responsiveness to both domestic emergencies and national contingency operations. The report shall set forth the measures taken, underway and projected to be taken to improve the timeliness, adequacy, and effectiveness of reserve component

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[24]U.S., Congress, Senate, Statement of Vice Admiral Donald F. Hagen, MC, Surgeon General United States Navy, April 14, 1994, Before the Subcommittee on Defense, Senate Appropriations Committee, pg. 10.

[25]Captain Paula A. Ryals, MC, USNR, "Military Medicine in Operations Other than War Part II: Humanitarian Relief Missions for Naval Reserve Fleet Hospitals", Military Medicine, vol. 161: September 1996, pg. 503.

responses to such emergencies and operations.[26]

Further, the Secretary of Defense's report is to address whether:

> Federal Law (should) be clarified and amended to authorize Presidential use of the Federal reserves of all military services for domestic emergencies and disasters without any time constraint.[27]

But the medical branch of the Naval Reserves has not yet played a noticeable role. This conclusion is based upon a review of the relevant and available evidence.

**4. Single-Sourcing of Fleet Hospitals**

The fourth change is referred to as "Single-Sourcing" of Fleet Hospitals. The term "Single-Sourcing" refers to the basic idea behind the new plan, that Fleet Hospitals are to be staffed from a single source, i.e., one command. Under this new plan, which is still being developed and implemented, Active Fleet Hospitals will now be "married" to specific CONUS MTF's. In the event an Active Fleet Hospital is deployed, the Active Component medical professionals normally assigned to a given MTF would deploy with the Active Fleet Hospital. Selected Reserve medical professionals would then backfill at the CONUS MTF, to take the place of the deployed Active medical professionals. Also, under the Single-Sourcing plan the number of Reserve Fleet Hospitals would increase to a total of

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[26]U.S., Congress, House, Defense Authorization Act FY97, H.R. 9067, 104th Cong., 2nd sess., 1996, pg. 9067.

[27]Ibid.

six.[28] Complete SelRes medical units would be assigned to either the CONUS MTF backfill mission or to a Reserve Fleet Hospital.

As alluded to above, this plan resulted from lessons learned during the Persian Gulf War. This plan came into being because of difficulties in fully manning both Active and Reserve Fleet Hospitals with the proper mix of medical professionals with the correct qualifications and credentials. As the GAO reported in 1996:

> In the past, Fleet Hospitals were staffed by pulling medical personnel from any location, but this approach did not work particularly well in Operation Desert Storm. The revised concept presumes that medical personnel who work together on a day-to-day basis will perform better than staff who are taken from different locations within the system.[29]

## C. CHAPTER SUMMARY

This chapter explained the roles and missions of the medical branch of the Naval Reserve, and how, by virtue of their support function, their roles and missions are inseparable from the roles and missions of the United States Navy Medical Corps. The causes of the endstrength changes are the end of the Cold War, the subsequent drawdown, and the need to make better use of the resources of the United States Navy. This chapter discussed four distinct areas (Active Component OPTEMPO\PERSTEMPO reduction, contributory support,

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[28]Government Accounting Office, "Wartime Medical Care: DoD Is Addressing Capability Shortfalls, but Challenges Remain," 25 September 1996, pg. 8.

[29]Ibid.

use of SelRes in humanitarian and peacekeeping operations, and Single-Sourcing of Fleet Hospitals) in which the roles and missions of the Reserves are changing.

# IV. TRAINING OF THE SELECTED RESERVES

## A. BACKGROUND

Chapter II provided a brief overview of the increase in the size of SelRes medical professionals from 1987 to 1995. This increase was explained in the larger context of the changing world order following the demise of the Soviet Union in 1990. Chapter III examined the various means by which this expanded medical force is being employed. Again, this is explained in terms of the end of the Cold War and downsizing of the active component.

This chapter will examine the training required for military medical professionals, particularly how it differs from its civilian counterparts. First, the difference between the practice of medicine in the military and the practice of medicine in a civilian environment will be reviewed. Once this difference is discussed, how the Navy trains their Reserve medical professionals is examined. How this training supports the changing roles and missions discussed in chapter III will then be reviewed.

## B. MILITARY VERSUS CIVILIAN MEDICAL PRACTICE

Explaining how the practice of medicine differs between the military environment and the civilian world may, at first, appear to be an exercise in futility. The treatment indicated for a gunshot wound or third degree burns should not change based upon how those wounds were inflicted. However, while the indicated treatment is unchanging, the environment in which the

treatment is provided affects the treatment itself. In other words, while the standard of care does not change, its achievement must take into account the environment in which care is provided. Achieving civilian hospital standards on the battlefield, in field hospitals or on hospital ships may be impossible. The practice of medicine outside the confines of an established hospital is fundamentally different. Albert E. Cowdrey summarized these difference in The Medic's War, in which he states:

> Military medicine was not, and could not be, the same as its civilian counterpart. It most resembled civilian medicine in the hospitals. It differed widely in preventive medicine, because soldiers lived so differently from civilians. It differed absolutely in the evacuation of battle casualties, and that has no parallel in civilian medicine.[30]

The DoD Inspector General explained the differences between military medicine and civilian medicine in its audit report on DoD Graduate Medical Education Programs and Medical Readiness Training. The report noted that the military doctor must meet the requirements of a civilian doctor plus:

> develop additional knowledge and skills to provide medical care in a hostile, wartime environment. Military physicians assigned to support aviation, infantry, mobile armor, shipboard, or undersea operations practice a vastly expanded form of medicine. Intimate knowledge of the work environment is required to recognize the hazards and stresses of the troops. An effective military physician has the capacity to move between a field and a fixed medical facility and provide quality care in both.[31]

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[30]U.S., Department of Defense, Office of the Inspector General, DoD Graduate Medical Education Programs and Medical Readiness Training, pg. 37.

[31]Ibid., pg. 2.

Another way that the environment affects the treatment provided is that the patient is removed from the battlefield through a series of care sites. The first echelon of care is the battlefield; the second echelon is an assembly point or clearing station; the third echelon is a field hospital; the fourth echelon is a general hospital external to the combat zone. Figure 2 represents the medical capabilities and relative mobility of each echelon.

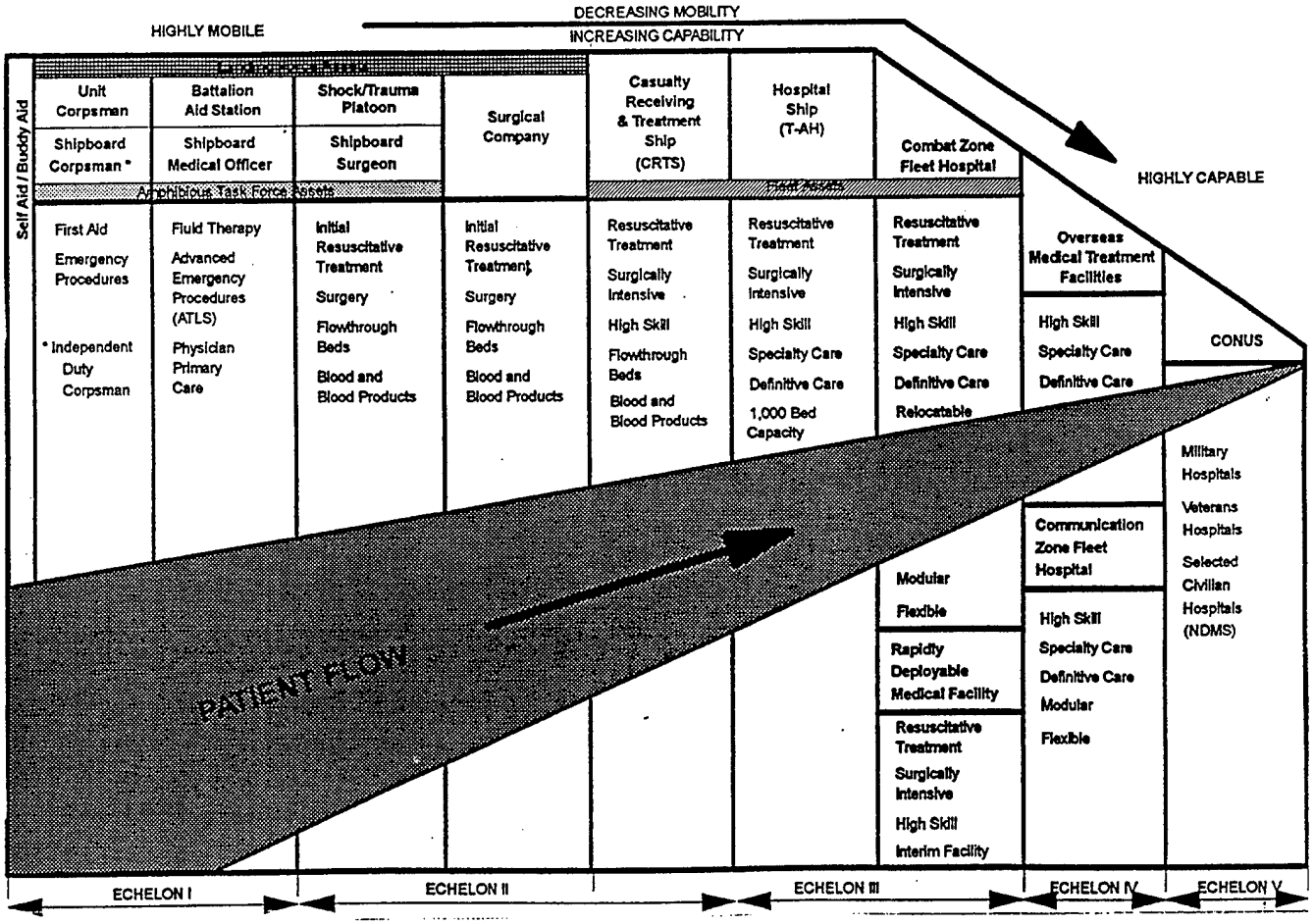


**Figure 2**

Source: United States Marine Corps, Marine Corps Warfighting Publication (MCWP) 4-2, Operational Health Service Support, Washington, D.C., February 22, 1996.

At each echelon, care is provided and a decision to evacuate the patient to the next higher echelon is made. Because of these echelons, continuity of care by the same physician is unlikely. This evacuation scenario may have civilian parallels (e.g., paramedics to emergency room to operating room to recovery), but movement over large geographic areas, including out of the theater of operations, is unlikely. Consequently, the capability of a military physician to consult a physician who provided treatment earlier in the treatment chain is substantially decreased.

As noted above, treatment for a given wound varies little based upon how it was inflicted. Nonetheless, the Emergency War Surgery NATO Handbook describes six differences between what they call "war surgery" and "surgery in the civilian setting". These differences are as follows:

- High-velocity weapons of war may produce tremendously greater tissue destruction than the low-velocity weapons producing civilian wounds.
- There are few civilian wounds which resemble the multiple fragment wounds of artillery or mortar shell bombs, booby traps, and land mines.
- The tactical situation may impose major constraints upon the performance of the indicated operation, and threats to the safety of the patient and medical personnel may make appropriate care inconvenient, if not impossible.
- Wounds are cared for by many surgeons along an evacuation chain that extends from combat zone to home, rather than by one surgeon and his staff throughout all phases of wound repair.
- Casualties are frequently received in large numbers over a short time in combat hospitals. Although an occasional catastrophe of

similar magnitude has occurred in a few metropolitan civilian hospitals, this is a commonplace occurrence in forward combat hospitals.

- During aeromedical evacuation, the casualty will require long flights during which lowered air pressure may complicate abdominal, chest, eye, head, and spinal wounds. The cabins of high altitude aircraft are pressurized only to about 4,000-8,000 feet above sea level, and not to sea level pressures.[32]

The first two of the six differences listed above relate to the type of wound inflicted. The remaining four relate to the environment in which treatment is provided. This highlights the importance of "military medical" training for SelRes medical professionals, assuming SelRes are expected to man Fleet Hospitals and Hospital Ships. This training requirement diminishes when the SelRes responsibility is to provide contributory support at CONUS medical treatment facilities.

In view of the differences between civilian and military medicine, a substantial training effort must be completed to transform a civilian medical professional (e.g., SelRes) to a military medical professional. This is particularly true if the physician is expected to serve in a combat zone hospital. This section will first examine the policies currently in place to effect this transformation. Second, this section will review the programs implemented to support these policies.

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[32]Emergency War Surgery NATO Handbook, Second U.S. Revision, 1988 as quoted in U.S., Department of Defense, Office of the Inspector General, DoD Graduate Medical Education Programs and Medical Readiness Training, pg. 39.

## C. TRAINING POLICIES

DoD Directive 1215.4, "Medical Training in the Reserve Component" is the primary document determining medical training policies. This directive lists and describes SelRes military medical training. The fundamental policy of this directive, and the guiding principle behind the training programs, is that training "shall ensure the maximum effectiveness of combat forces during wartime."[33]

To support this goal, the directive states five policies. These policies are as follows

- SelRes units should train in peacetime with the unit they would work with in wartime.
- Field training and command post exercises should regularly include SelRes.
- There is interaction between RC [Reserve Component] and civilian healthcare personnel at civilian academic institutions through the use of RC medical training opportunities.
- Reserve Healthcare personnel are given flexible Reserve training opportunities.
- Reserve healthcare personnel are authorized to attend continuing health education courses.[34]

These policies reflect the varied roles and missions expected to be fulfilled by Selected Reserve medical professionals. The first two policies indicate an understanding of the differences in the practice of medicine between military and

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[33]Department of Defense Directive 1215.4, "Medical Training in the Reserve Components", November 27, 1990, pg. 1.

[34]Ibid., pg.1.

civilian environments. These two policies support both the increased use of SelRes to provide humanitarian and peacekeeping assistance, and reduction of the Active Component OPTEMPO/PERSTEMPO. By training SelRes outside the conventional hospital environment, they can better support the roles of humanitarian and peacekeeping assistance and reduction of the OPTEMPO /PERSTEMPO of the Active Component. This training helps SelRes medical professionals to be ready to instantly integrate and practice medicine with their gaining wartime command.

The final three policies reflect the need to simply maintain qualified, credentialed medical professionals in the Selected Reserves. This supports all four changing roles and missions, since qualified, credentialed medical professionals are essential to all four roles and missions. Accurate credentialing of SelRes medical professionals is particularly important to the contributory support mission. Surgeon General VADM Hagen pointed this out when he explained a new initiative to improve credentialing of Reservists:

> One initiative that is especially impressive is the newly opened Centralized Credentials Review and Privileging Activity (CCPA) in Jacksonville, Florida. The CCPA centralizes the credentialing of all reserve providers to improve readiness and increase contributory support. It is the first activity of its kind, not only within the Department of Defense, but also within the American health industry. The mission of the CCPA will be expanded to include credentialing of active duty health care providers in the future.[35]

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[35]U.S., Congress, Senate, Statement of Vice Admiral Donald F. Hagen, MC, Surgeon General United States Navy, April 14, 1994, Before the Subcommittee on Defense, Senate Appropriations Committee.

Finally, the directive bridges the gap between training and contributory support by stating that Reserve Medical units can be required to drill at hospitals of the Uniformed Services when appropriate.[36]

## D. TRAINING PROGRAMS

The DoD has five training programs for medical personnel. These are "Warams", "Medrex", "Reflex", "Primus", and "Cheer".[37] These programs will be described in depth below. Interestingly, the introduction to the "Programs" section of DoD directive 1215.4 states that these "training programs are designed to attract and retain appropriate healthcare personnel, with the desired skills, into the R(eserve) C(omponent)."[38] The significance of this statement lies in the wording of the above sentence. The ability of these programs to "attract and retain" suggests that they serve a recruiting and retention function as well as a training function.

Nevertheless, these programs reflect the changing roles and missions of the medical branch of the Naval Reserve. As discussed in chapter III, these are reduction of the Active Component OPTEMPO/PERSTEMPO, contributory support, humanitarian and peacekeeping assistance, and Single-Sourcing of Fleet Hospitals.

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[36]Ibid., pg. 2.

[37]Ibid., pg. 7.

[38]Ibid., pg. 4.

A summary of Reserve Component medical training programs follows.

- **Wartime Alignment of Reserve and Active Medical Systems. (WARAMS)** A training program designed to maximize the mobilization readiness and operational effectiveness of medical units and members. The objective of WARAMS is to integrate maximally the reserve and active medical units and members so that their members who may work together in wartime may train together in peacetime.

- **Medical Readiness Exercises. (MEDREX)** MEDREX are designed to allow RC medical units and members to participate fully with the active forces in command post and field training exercises. The purpose of MEDREX is to increase operational readiness capabilities to meet wartime medical support requirements. For maximum effectiveness, exercises are conducted at actual wartime employment locations in the United States and in potential overseas theaters of operations.

- **Reserve Flexibility. (REFLEX)** REFLEX provides an opportunity for RC healthcare personnel to receive Reserve pay and/or retirement points by developing flexible scheduled training programs, instead of traditional unit training assemblies. Training credit may be approved for those activities that would contribute to the wartime medical readiness of the individual. The activities... must enhance the individual's military medical readiness.

- **Continuing Health Education to Enhance Readiness. (CHEER)** CHEER enable(s) healthcare personnel to maintain and enhance their professional skills and to help them meet professional certification, recertification, and licensure requirements while simultaneously contributing to mobilization readiness.

- **Physician Reservists in Medical Universities and Schools. (PRIMUS)** PRIMUS is a medical training program that provides RC physicians with opportunities to earn Reserve pay and retirement point credits while performing IDT (Inactive Duty for Training) and ADT (Active Duty for Training) with medical universities and schools.[39]

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[39]Ibid., pg. 4.

WARAMS and MEDREX meet the policy goals of field medical training and reserve integration. The remaining programs (REFLEX, CHEER, and PRIMUS) emphasize continuing education through civilian institutions. Ensuring currency of skills, certifications, and licenses is essential to medical readiness and speaks to the issue of retaining qualified, credentialed medical professionals in the Selected Reserves. As noted in the DODIG audit report on Graduate Medical Education, the first requirement for a doctor to be a good military physician is to meet the requirements of a civilian doctor.[40]

Another area where training illuminates changing roles and missions of the medical branch of the Naval Reserve is attendance at the Fleet Hospital Operations Course (FHOC). This ten day course provides training in the construction and day-to day operation of a Fleet Hospital. Figure 3 shows that between 1988 and 1989, Active and Reserve attendance at the course essentially reversed. From a peak level of more than 70 percent in 1987 and 1988, active attendance has gone to near zero. Attendance from 1989 has been dominated by Reserve personnel.

These data would seem to support the idea that Reserves are currently being used to provide reduction of the Active Component OPTEMPO/ PERSTEMPO and are preparing to be used in humanitarian /peacekeeping missions. Reserve FHOC attendance would support both of these roles and

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[40]U.S., Department of Defense, Office of the Inspector General, DoD Graduate Medical Education Programs and Medical Readiness Training, pg. 4.

missions. By increasing areas in which SelRes are trained, this increases the possible ways in which a SelRes could be assigned in order to reduce Active Component OPTEMPO/PERSTEMPO.

Although Fleet Hospitals (Active and Reserve) have not deployed for humanitarian or peacekeeping missions, they are an ideal platform for that mission. "Naval Reserve Fleet Hospitals represent modular, interchangeable, relatively self-sustaining units that can be rapidly deployed".[41] In an environment requiring humanitarian and peacekeeping assistance, the normally-existing infrastructure, i.e., electricity, water, and sanitation may be non-existent. The self-sustaining capability of a Fleet Hospital is, therefore, essential in the humanitarian and peacekeeping mission. This capability, combined with the fact that Reserves are being trained to operate Fleet Hospitals, suggests the possibility of using the Reserves for the humanitarian and peacekeeping mission.

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[41]Captain Paula A. Ryals, MC, USNR, "Military Medicine in Operations Other than War Part II: Humanitarian Relief Missions for Naval Reserve Fleet Hospitals", Military Medicine, vol.161: September 1996, pg. 503.

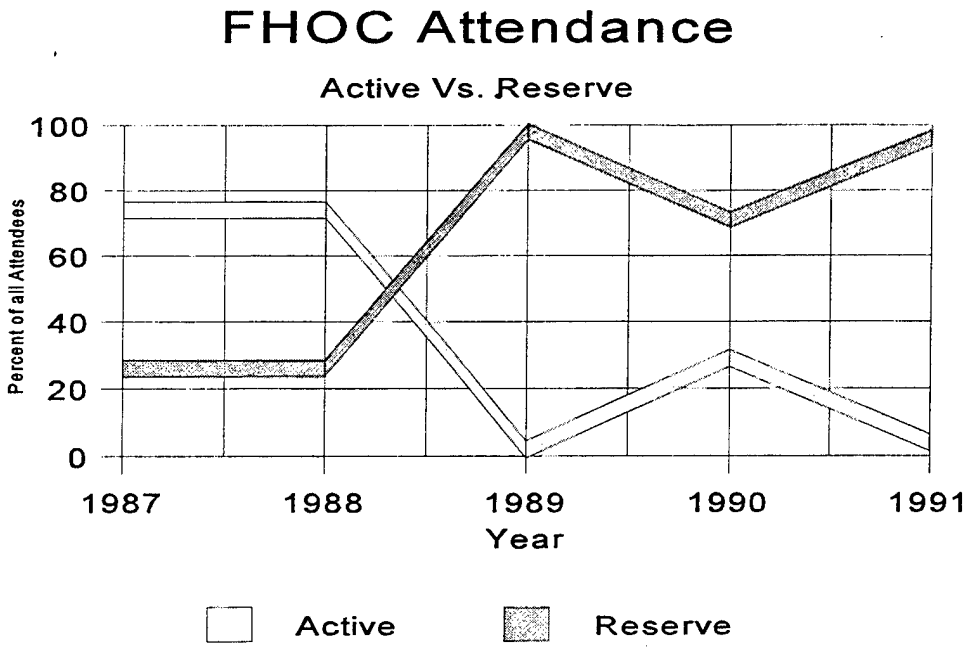


**Figure 3**

Source: U.S., Department of Defense, Office of the Inspector General, Medical Mobilization Planning and Execution, Report 93-INS-13, September 30, 1993, pg.70.

## E. CHAPTER SUMMARY

This chapter demonstrated that a significant difference exists between a civilian medical professional and his military counterpart. This difference is based, primarily, upon the locations and environments in which the military medical professional may be required to practice medicine. In other words, the practice of medicine in a CONUS Medical Treatment Facility is not substantially different from the practice of medicine in a civilian hospital. On the other hand,

the practice of medicine in a field hospital or hospital ship is drastically different from the practice of medicine in a civilian hospital. Because of these differences, the training military medical professionals receive serves to highlight the manner in which they will be employed.

It has also been shown that the mix of training a Selected Reservist medical professional receives reflects the area in which the Navy desires to increase his level of proficiency. These areas are Fleet Hospitals (WARAMS, MEDREX, FHOC attendance) and professional education (REFLEX, CHEER, PRIMUS). Both areas (Fleet Hospital and professional education) support the expanded roles and missions discussed in Chapter III. As noted, Fleet Hospital training of SelRes supports the mission of humanitarian and peacekeeping assistance, and reduction of the Active Component OPTEMPO/PERSTEMPO. Professional education supports all changing missions by maintaining qualified, credentialed medical professionals in the Selected Reserve.

As seen in chapter III, SelRes medical professionals have yet to actually participate in humanitarian/peacekeeping missions. However, increased attendance by Reservists at the FHOC school imply an increased expectation of Reservists serving in Fleet Hospitals. This expectation, combined with the unique capabilities of the Reserve Fleet Hospital, indicate a potential increased role for the Naval Reserve Medical force in humanitarian and peacekeeping operations.

# V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter briefly summarizes the information in the preceding chapters and presents conclusions based on that information. Recommendations for further study are presented separately, following the summary and conclusion sections.

## A. SUMMARY

Chapter I provided a short discussion of the recent history of the medical branch of the Naval Reserve and placed it in historical context with respect to world events, especially the Persian Gulf war and the end of the Cold War. The primary objective of this thesis, namely examining the changing roles and missions of the medical branch of the Naval Reserve during the period 1987 to 1995, was presented. Chapter I also presented the research questions, methodology, and organization of study used to achieve the primary objective. The primary questions presented were how did the roles and missions of the medical branch of the Naval Reserve change during the period of the post-Cold War drawdown from 1987 to 1995; and how has the medical branch of the Naval Reserve changed demographically because of these new roles and missions.

Chapter II provided a broad overview of the Naval Reserve in general and the medical branch of the Selected Reserves in particular. The various categories of Reservists (i.e., Active vs. Inactive, Selected Reserves vs. Individual Ready Reservists) were discussed. The chapter pointed out that the focus of this thesis would be on SelRes medical professionals (defined as

doctors, nurses, dentists, and Medical Service Corps) since they are the first to be mobilized in the event of conflict.

Chapter II also identified of the various programs the Selected Reserves support. The relative size and manning priority of these programs were examined. Program 32 and 46 account for approximately 92 percent of all Selected Reserve medical professionals. The chapter closed with a review of the statistics contained in the DMDC study "Navy Health Care Right-Sizing, a Comparative Demographic Profile of the Department of Defense Workforce, September 1987 versus September 1995". This study showed that during this period the number of Selected Reserve medical professionals increased 89 percent while total Navy endstrength decreased 28 percent.

Chapter III described the changing roles and missions of Selected Reserve medical professionals as a way to understand the change in demographics described above. How those changes have been brought about by the end of the Cold War and the Persian Gulf War was also discussed. The chapter identified these changing roles and missions as the use of SelRes medical professionals to reduce the OPTEMPO/PERSTEMPO of the Active Component, to provide contributory support at CONUS MTFs, to assist in humanitarian/peacekeeping efforts, and single-sourcing of CONUS MTFs. The first two changes, reduction of the Active Component OPTEMPO/ PERSTEMPO and contributory support, are revolutionary in nature and they are actively being conducted. The second two are evolutionary in nature and are still in their

nascent stage.

Chapter IV indicated the circumstances and manner in which the practice of medicine in the military is different from the civilian world. This information is necessary to explain the training policies and programs the Naval Reserve uses to transform a civilian medical professional into a military medical professional. Chapter IV concluded by showing how these training programs and policies support and reflect the changing roles and missions of the medical branch of the Naval Reserve. Chapter IV showed that WARAMS (Wartime Alignment of Reserve and Active Medical Systems), MEDREX (Medical Readiness Exercises), and FHOC (Fleet Hospital Operation Course) supported Fleet Hospital training while REFLEX (Reserve Flexibility), CHEER (Continuing Health Education to Enhance Readiness), and PRIMUS (Physician Reservists in Medical Universities and Schools) support professional education.

## B. MAIN CONCLUSIONS

In an attempt to continue meeting worldwide obligations in an environment of force reduction brought about by the end of the Cold War, the Navy has modified its use of the medical branch of the Naval Reserve in three ways. First, the Navy has increased use of the medical branch of the Naval Reserve in the form of reduction of the Active Component OPTEMPO/PERSTEMPO and contributory support. Second, the capability for SelRes medical professionals to provide humanitarian or peacekeeping assistance has been improved but no substantial evidence currently exists that this capability is being used by the

Naval Reserve. Third, as the single-sourcing of Fleet Hospitals is implemented, this initiative will significantly task the medical branch of the Naval Reserve by requiring Selected Reserves to completely backfill at an MTF being mobilized as a Fleet Hospital.

## C. RECOMMENDATIONS FOR FURTHER STUDY

The following issues should be considered possible topics for further study.

1. At a single CONUS MTF, examine total contributory support provided by Selected Reserve medical professionals in a given time period. This can be measured in terms of patients seen, and/or procedures performed. Evaluate the impact on hospital costs and patient satisfaction. Evaluate the "value-added" to the healthcare provided.

2. Under the single-sourcing plan currently being implemented by BUMED, Selected Reserve medical professionals will fully staff six Reserve Fleet Hospitals in addition to backfilling CONUS MTFs designated as Fleet Hospitals in the event of mobilization. Evaluate whether there are sufficient SelRes medical professionals to meet this requirement. Compare these findings with those of the "733 Study" and the requirements of the THCSRR-MOSR model.

3. Using this thesis as a basis, perform a cost comparison between the 1987 numbers of all medical professionals (Active plus Reserve) and the 1995 numbers of all medical professionals. Base this study on costs of base pay, retention bonuses, drill pay, travel costs, etc. This study can then provide the

basis of a cost comparison of the Selected Reserve medical professionals versus their Active Component counterparts.

4. Examine the substantial increase in attendance by Selected Reservists at Fleet Hospital training. Is the training adequate to support the single-source staffing of the Reserve Fleet Hospitals? Examine further the reason behind the increase in attendance at the FHOC course, in view of the fact that SelRes have yet to be employed in the humanitarian/peacekeeping mission. Finally, if the training is adequate, why have the Reserve Fleet Hospitals not been used in this mission.

## LIST OF REFERENCES


Binkin, Martin, U.S. Reserve Forces: The Problem of the Weekend Warrior, The Brookings Institute, Washington DC, 1976.

Bureau of Medicine and Surgery, BUMED Instruction 1001.3, "Integration, Use and Training of Reserve Medical Personnel", 20 April 1993.

Commander, Naval Reserve Surface Force Instruction 5400.1b, 1 July 1996.

Commander, Naval Reserve Forces, New Orleans, LA, Radio Message Dated 112000Z July 1996.

Copenhaver, Kimberly A., Navy Health Care Readiness Requirement Model and Programming Costs, NAVAL POSTGRADUATE SCHOOL Thesis, Dec 1994.

Department of Defense Directive, DOD 1215.4, "Medical Training in the Reserve Components," 27 November 1990.

Defense Manpower Data Center, Navy Health Care Right-Sizing: A Comparative Demographic Profile of the Department of Defense Workforce, September 1987 versus 1995, April 1996.

Dwine, Steve, LCDR, USN, Bureau of Medicine and Surgery, Medical Resources, Plans and Policies, (N-931D). Telephone interview. 15 July 1996.

Ericksen, Nancy, CDR, NC, Commander, Naval Reserve Force, Code 006B, Telephone interview. 22 July 1996.

Hagen, Vice Admiral Donald F., MC, Surgeon General United States Navy, Statement Before the Subcommittee on Defense, Senate Appropriations Committee, April 14, 1994.

Heller, Charles E., Total Force: Federal Reserves and State National Guards. Army War College, Dec 1994.

Joint Chiefs of Staff, Washington, D.C., Radio Message dated 052202Z February 1996.

Joseph, Dr. Stephen, "Military Medicine: In Step, Adept, Flexible", Prepared remarks to the DoD TRICARE Convention, Washington, D.C., January 22, 1996.

Lee, Deborah, Prepared Remarks to the AMSUS Convention, Los Angeles, CA, October 30, 1995.

Maiello, Rick, LCDR, MSC, USNR, Bureau of Medicine and Surgery, Reserve Integration, (MED-07). Telephone interview. 23 July 1996.

Moore, Daryce L., Total Force: The Reserve Recall Process and Desert Shield/Desert Storm, NAVAL POSTGRADUATE SCHOOL Thesis, Jun 1991.

Report of the Reserve Forces Policy Board, Department of Defense, Fiscal 1987, 1991, 1995.

Department of the Navy, A Report to the Congress on the Navy's Total Force for Fiscal Year 1985, United States Government Printing Office, 1985.

Department of the Navy, A Report to the Congress on the Navy's Total Force for Fiscal Year 1987, United States Government Printing Office, 1987.

Department of the Navy, A Report to the Congress on the Navy's Total Force FY 1991, United States Government Printing Office, 1991.

Shalikashvili, Gen. John M.,"The DoD-CARE Humanitarian Connection". Prepared Remarks to the CARE 50th Anniversary Symposium, Washington, D.C., May 10, 1996.

United States Congress, House, Defense Authorization Act FY97, H.R. 9067, 104th Congress, 2nd session, 1996.

United States Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), FY96-01 Defense Health Program (DHP) Program Objective Memorandum (POM), Washington, D.C., 8 June 1994.

United States Department of Defense, Office of the Assistant Secretary of Defense (Reserve Affairs), "An Introduction to the Reserve Components of the United States", Washington, D.C., 21 February 1995.

United States Department of Defense, Office of the Inspector General, DoD Graduate Medical Education Programs and Medical Readiness Training, Report Number 96-168, June 18, 1996.

United States Department of Defense, Office of Program Analysis and Evaluation, "The Economics of Sizing the Military Medical Establishment," Executive Report of the Comprehensive Study of the Military Medical Care

System, Washington, D.C., March 1994.

United States Marine Corps, Marine Corps Warfighting Publication (MCWP) 4-2, Operational Health Service Support, Washington, D.C., February 22, 1996.

Weber, Timothy, LT USN, Bureau of Medicine and Surgery, Medical Resources, Plans and Policies, (N-931D). Telephone interview. 17 July 1996.

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